



Achievement Center's Summer Treatment Program Application

Child's Name _____ Date _____

Social Security #: _____ Date of birth _____

Age ____ Male: ____ Female: ____ Home Phone _____

Parent/Guardian _____ Work Phone _____

Address _____ Cell Phone _____

_____ Referral Source _____

Living Arrangements (if different): MA Card # _____

Name _____ MA Card Issue # _____

Address _____ Insurance Group _____

_____ Insurance ID# _____

Phone _____

School District _____ School Name _____

School Contact Person _____ Grade _____

IEP/Special Needs? Yes ____ No ____ Specify needs: _____

Other Agency Involvement (BHRS, OP, C&Y, Juvenile Probation, Drug & Alcohol, etc.)

Agency: _____ Contact Person _____ Phone _____

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Mental Health Diagnosis (list) _____ Diagnosis Given by _____

_____ Date of recent evaluation _____

Describe Strengths : (Child's positive attributes, interests, etc.) _____

Describe Concerns: (Concerns in each environment and how long have they existed)

Home: _____

School: _____

Community : _____

Other: _____

Behavior and Social (Complete brief summary for the following)

Peer Relations: _____

School Performance: _____

Any special needs (physical, educational, dietary, etc.) _____

Medical History:

Current Medications: _____

Prescribing Physician: _____

What mental health services is your child currently receiving? _____

Agency: _____ Contact Person: _____ Phone: _____

Primary Care Physician _____ Phone _____

Hereditary Disorders: _____

Allergies: _____

Medical Conditions: _____

Physical Limitations: _____

Birth History: (prenatal care, delivery complications, etc.) _____

Developmental History (walking, talking, toilet training, etc.) _____

What are your goals pertaining to you child being involved with STP? _____

What expectations do you have in regards to your child's experience in this program? _____

Will you be able to attend weekly parent groups? Yes _____ No _____

- Children are expected to **attend all sessions**.
- The Program is therapeutic in nature and activities are designed and planned to maximize therapeutic impact using nationally recognized and standardized protocols.
- Parents need to be actively involved with daily consultation and weekly parent training.
- Referrals to more appropriate Mental Health Services may be recommended if indicated.

Signature _____ Date _____

Relationship to child: _____

Please send applications to **Achievement Center**
Attn: STP Liza Suhr
P.O. Box 457
18257 Industrial Drive
Meadville, PA 16335